HEALTH AND COMMUNITY SUPPORTS CONTRACT

CONTRACT INTERPRETATION BULLETIN

for CY 2002 Contract

CIB #2002-1:Notice and Member Consent to Changes

CONTRACT SECTIONS AFFECTED

Article III. B.7. *Individual Service Plan and Member-Centered Plan Development*
Article IV. D. Notification to Members

STATEMENT OF POLICY

Notice of changes in care plans informs the member about the changes made and about the member's options to review or discuss these changes, including the right to complain or file a grievance. Notice of change also assists the CMO. Actual notice begins the time period in which a member can continue to receive certain services while a complaint or grievance is pending. The notice of changes assures the parties are aware of options and timeframes for resolving differences in the absence of agreement.

The Health and Community Supports contract requires the CMO to obtain member's signature on the initial care plan within 10 days of enrollment. The contract also requires that the member-centered plan (MCP) and individual service plan (ISP) that are developed based on the comprehensive assessment be completed within 60 days of enrollment, that they be updated at least every 180 days, that they be reviewed with and signed by the member or member's authorized representative, and that the member be provided with a copy of the signed ISP/MCP. The signature is verification that the plan has been reviewed with the member and the member agrees with the plan. The signature requirement protects the member from changes in services that are not agreed to, and also protects the CMO from subsequent claims that the member did not agree to services.

The question of what changes on the ISP/MCP between formal reviews require written notification to the member has been the subject of ongoing discussion between CMOs and DHFS.

AUTHORITY FOR CONTRACT PROVISIONS

Federal regulations identify a 10-day advance notice requirement at 42CFR431.211 for adverse changes in a member's care plan. Federal regulations go on to list about nine exceptions to the notification requirement (at 42CFR431.213). Included among the exceptions is written agreement of the member with the adverse change in the care plan.

HFS 10, the Family Care Administrative Code, specifies at 10.55 Fair Hearing that among the matters that members may contest through a fair hearing is if the care plan

"requires the enrollee to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the enrollee."

CONTRACT INTERPRETATION

1. MCP/ISP – Once a MCP/ISP is established for a member, it must be reviewed by the interdisciplinary team, including the member and his/her representatives, at least every 180 days. The CMO will obtain the member's signature on the care plan at least every 180 days.
   [Health and Community Supports contract at Article III. B.7. *Individual Service Plan and Member-Centered Plan Development*]

2. Adverse Action –
   a. Except as allowed in paragraph b, the CMO must mail a notice at least 10 days before the date of the intended action for any of the following:

      (i) Denial, termination, reduction or suspension of previously authorized services.
      (ii) Authorization of a service in an amount, duration, or scope that is less than requested.
      (iii) Service authorization decisions not reached within the timeframes specified in the contract (such lack of response constitutes a denial and thus an adverse action).

   b. An exception to this requirement is if the CMO has obtained, prior to the date of the intended action, a clear written statement signed by the member that he or she no longer wishes the service. A signature on an MCP/ISP would meet this criterion. In this situation, federal regulations require that the CMO still provide written notice, but may do so up until the date of action – the notice does not need to be sent 10 days prior to date of intended action.
      [Health and Community Supports contract, Article IV. D. *Notification to Members*, HFS 10.52, s. 46.287(2) Stats., 42CFR431.213(b)].

3. Increase in Services –
   a. If the member agrees to the increase, the CMO case manager must document in case notes that he or she has discussed the increase in services with the member, and that the member wants the increase in services. The only requirement for a member's signature to document approval of an increase in services is the member's signature on the updated ISP/MCP at the next regularly scheduled review.

   b. If the member does not want the increase in services, and the CMO will provide them anyway, this is considered an adverse change in the care plan and the CMO must provide 10-day written notice to the member before making the change in the plan.

For service increases in the ISP/MCP, the CMO case manager must document that he or she has discussed the increase in services with the member, and that the member wants the increase in services.

If the member does not want the increase in services, and the CMO will provide them anyway, this is considered an adverse change in the care plan and the CMO must provide 10-day written notice to the member before making the change in the plan.